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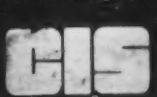

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A GUIDE TO PURCHASING MEDIGAP AND LONG-TERM CARE INSURANCE

(Annotated)

AN INFORMATION PAPER

PREPARED FOR USE BY THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

AUGUST 1990

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PREFACE

Medicare does not cover all the health care costs of its elderly and disabled beneficiaries. In fact, Medicare beneficiaries with large health care expenses may face significant amounts of out-of-pocket costs.

The gaps in Medicare combined with the high costs of health care mean that many older persons have an understandable desire to purchase additional insurance. The private health insurance market has responded to this demand with various types of policies. These include (1) "Medigap" policies and Health Maintenance Organizations (HMOs), which are designed to fill the gaps in Medicare; and (2) long-term care policies, which are designed to cover nursing home and home health care services.

Unfortunately, selecting appropriate supplemental and long-term care health insurance can be a bewildering and complex task. The repeal of the Medicare Catastrophic Coverage Act has made this task even more difficult. Moreover, beyond the everyday complexities of Medicare and Medicaid, many serious marketing problems within the Medigap or supplemental insurance industry persist.

Despite over a decade of State and Federal regulatory efforts, reports of agent ignorance, high-pressure marketing techniques, and agent and insurance company efforts to sell unnecessary Medigap policies continue. Older Americans remain vulnerable, often falling prey to abusive sales tactics and confusingly worded policies.

A March 1990 Aging Committee hearing and investigation documented a number of problems. These included continued widespread misuse of "cold lead" cards—mass mailed advertisements used to target potential purchasers of a product; the establishment of phony senior citizen's organizations whose mailing lists are used to target insurance leads; and an agent training

manual which directs agents to intentionally mislead or scare the elderly consumer. In addition, the Committee found many cases in which agents had duped elderly individuals into purchasing as many as 18 policies with overlapping coverage.

Congressional hearings and investigations have revealed that the same types of abusive marketing practices that pervade the Medigap insurance market may be carrying over to the long-term care insurance market. Recognizing the growing need for long-term care, insurance companies have included long-term care policies along with the Medigap policies they offer. A rapidly growing number of policies have become available on the private market, each offering a variety of benefits under a wide range of circumstances. This makes the task of choosing a long-term care policy both confusing and difficult.

Recognizing continued problems surrounding the affordability and marketing of Medigap insurance policies, legislation has been introduced in the Senate and the House, including legislation sponsored by the Chairman and ranking member of this Committee, that will make important improvements to the Medigap market. The bills address crucial areas for reform: simplification, duplication, loss ratios, agent commission structures, counseling programs, and premium increases.

By focusing on these areas, the legislation will bring effective, comprehensive reform to this market. The pending legislation represents a bipartisan, cooperative effort on the part of Congress, the health insurance industry, and consumer groups to craft a reasonable, effective approach to remedying the ills of the Medigap market.

S. 2189, The Health Insurance Counseling and Assistance Act of 1990, introduced by Senators Pryor, Heinz, and others, gives States money to establish health insurance counseling and assistance programs. A counseling and assistance program provides the opportunity for a Medicare beneficiary to seek objective advice about the adequacy of their current coverage. Coupled with proposed Medigap market reform, counseling programs can be an effective remedy to marketing and sales abuses. As of this writing, it appears that Medigap market reform legislation is likely to pass during this session of Congress.

To assist older Americans in purchasing Medigap and/or long-term care insurance, and to help clear up some of the confusion that pervades the private insurance market, the U.S. Senate Special Committee on Aging has prepared this information paper. In providing this document, the Aging Committee hopes to assist older Americans in making better informed decisions about their health care insurance.

A number of individuals contributed to writing and reviewing this information paper. Several individuals should be singled out for their fine contributions in preparing this document, including Elizabeth Vierck, Ann Trinca, and Bonnie Burns. In addition, staff members of the National Association of Insurance Commissioners, the American Association of Retired Persons, the Congressional Research Service, and the Health Care Financing Administration provided extremely valuable and much appreciated assistance. Finally, a number of Aging Committee staff, in particular Anna Kindermann, Bonnie Hogue, William Benson, and Chris Jennings spent numerous hours focusing, writing, and editing this document. The end product reflects well on all who contributed to it, and demonstrates their knowledge and commitment to the field.

DAVID PRYOR,
Chairman.
JOHN HEINZ,
Ranking Minority Member.

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EXPLANATION OF TERMS

Accident Only Policies.—A type of health insurance that provides coverage for death, dismemberment, or hospital and medical care due to an accident.

Allowed/Medicare Approved Charge.—A charge determined by the insurer to be the maximum amount paid to a participating physician.

Assignment.—A provision in a Medicare provider's plan that states that a provider who accepts assignment also agrees to accept the amount of reimbursement determined by Medicare as payment in full; the provider then collects from the patient only the applicable deductible and 20 percent coinsurance amounts.

Co-insurance/Co-payment.—A percentage or amount of health expense for which you are responsible under an insurance plan.

Confinement Period.—The period of time which long-term care policies require that you stay out of the hospital before you will have to go through a new waiting or deductible period.

Custodial Care.—Care that is primarily for meeting personal needs such as help in bathing, dressing, eating, or taking medicine. It can be provided by someone without professional medical skills or training but must be according to a doctor's orders. Custodial care does not involve skilled care services and/or intermediate health-related care.

Deductible.—Amount of covered expenses which you must pay before your insurance plan will pay its benefits.

Dread Disease Policy.—A policy which provides coverage for a serious specific disease or diseases (frequently cancer), in which benefits are usually tied to hospitalization (a flat fee is paid for each day of hospitalization).

Elimination Period.—Period of time before benefits will be paid. (See also waiting period.)

Guaranteed Renewable.—An insurance contract where the insurer agrees to continue insuring you for a certain time period, or for life, as long as you pay the premium.

Health Care Financing Administration (HCFA).—A Federal agency (part of the Department of Health and Human Services) which administers Medicare and Medicaid.

Health Maintenance Organizations (HMO's).—An organized health care delivery system which provides a wide range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.

Health Underwriting.—The process by which an insurer determines whether or not and on what basis it will accept an application for insurance based on the medical history and physical condition of the applicant.

Home Health Care.—A wide variety of services provided in the home which include nursing, therapy, personal care, and home health aides/homemaker services.

Hospice Benefit Period.—Under Medicare, the period of time a qualified person may elect hospice care services in lieu of regular Medicare benefits. Persons who qualify for hospice care may elect three hospital periods of 90, 90, and 30 days for a total of 210 days of coverage.

Hospice Care.—A mode of care that emphasizes pain relief and comfort rather than curative care for patients for whom there is no chance of a cure. Such care is designed to help terminally ill patients remain free from pain and in the home or home-like environment as long as possible.

Hospital Indemnity Policy.—A policy which pays its benefits in cash on a daily basis when you are hospitalized.

Intermediate Care Facility.—Generally, health-related care provided in nursing homes that includes care provided by skilled nursing or rehabilitative professionals, as well as nonskilled care provided by para-professionals such as nurse aides.

Lifetime Reserve Days.—Under Medicare's Hospital Insurance Program (Part A), benefits for 60 additional hospital days which you can use over your lifetime if

you have an illness and have to stay in the hospital for more than the 90 days covered in a benefit period.

Long-Term Care Insurance.—Insurance policies that may cover a range of medical, personal, and social services delivered over time to meet the needs of chronically ill or disabled persons.

Medicaid.—A Federal/State cooperatively funded and State operated program of health benefits to low-income persons.

Medicare.—A Federal health insurance program for persons aged 65 and over who are eligible for Social Security or Railroad Retirement benefits, and for some people who are under age 65 who are disabled, and meet Medicare's disability requirements.

Medigap.—Private health insurance designed to supplement Medicare by covering the gaps, and often some additional services, not paid for by Medicare.

National Association of Insurance Commissioners (NAIC).—A national organization of State executives representing State insurance commissions or departments that develops model legislation and regulations on insurance.

Participating Physician.—A physician who has agreed in advance to accept assignment on all Medicare claims for a 1-year period.

Pre-Existing Condition.—A physical and/or mental condition suffered by an insured individual that existed prior to the effective date of the policy. Insurance policies may limit benefit payments for pre-existing conditions.

Premium.—The amount that must be paid to purchase an insurance policy or keep it in effect.

Primary Care.—Basic or general health care—the patient's usual entry point into the medical care system.

Probationary Period.—A period from the policy's effective date to a specified time, usually 15–30 days later, during which no coverage is provided.

Skilled Nursing Facility Services or Care.—Generally skilled care and rehabilitation services provided to sick and injured persons by skilled personnel such as registered nurses or therapists.

Waiting Period.—Period of time that must pass (after the effective date of coverage) before the policy will provide benefits for a pre-existing condition or that must pass before benefits are provided.

Wavier of Premium.—Provision in a long-term care policy that allows the policyholder to stop paying the premium while in a nursing home.

INTRODUCTION

The Medicare Program was never intended to cover all the health care costs of the elderly and disabled population it serves. Yet, over the last decade medical costs and the gaps in Medicare coverage have grown far more than anyone could have anticipated. To fill these gaps, insurance companies have developed insurance policies (often termed Medigap) to supplement Medicare coverage, which an estimated 75 percent of the Nation's older Americans have purchased. In addition, 5 percent of the Nation's elderly have purchased long-term care policies. Unfortunately, purchasing Medicare supplemental and long-term care insurance can be a confusing and expensive challenge.

This guide is intended to make that job easier. It is not intended to be the final word on choosing private insurance. In its limited space, this guide should help answer some basic questions about how to fill the gaps in your Medicare coverage. For example:

- What does Medicare pay for?
- What doesn't Medicare cover?
- What do I need to do to close the gaps in Medicare coverage?
- How can I get the best Medicare supplemental coverage for my money?
- What options are available to me for protecting against long-term care costs?
- What are some of the common pitfalls I should avoid in choosing a Medigap policy and/or a long-term care policy?

THE MEDICARE PROGRAM

The Medicare Program is divided into two parts, referred to as Part A and Part B. Part A covers hospitalization costs, and Part B covers physician and surgeon charges in and out of the hospital, as well as other medical charges out of the hospital. (NOTE: The lower left hand side of your Medicare card will indicate the coverage you have, Part A or Part B, or both.)

PART A (HOSPITAL INSURANCE)

You receive Part A of Medicare automatically at age 65 if you are eligible for Social Security or if you qualify for disability benefits. If you are 65 and not automatically eligible for Social Security, you can obtain coverage by paying a monthly premium of $175 (1990 amount).

If you are hospitalized, Part A covers the charges customarily associated with a hospital bill, including charges for a semi-private room, meals, nursing services, a special care unit, operating and recovery rooms, medical supplies and appliances, rehabilitation services, and, if billed by the hospital, drugs, and laboratory and radiology services. In addition, Part A covers medically necessary in-patient care in a Medicare certified skilled nursing facility, or SNF, after a hospital stay of at least 3 days, as well as home health care (Medicare covers only medically necessary skilled care), and hospice care. For SNF care Medicare covers 100 percent for the first 20 days; from the 21st day through the 100th day, Medicare covers costs after a required co-insurance charge of $74 (1990 amount) a day.

You should remember that most nursing homes are not Medicare certified skilled nursing facilities. In addition, Medicare does not cover custodial care—the level of care most commonly needed by those with chronic illnesses.

Medicare measures the quantity of services it covers according to a *benefit period.* Medicare will pay for up

to 90 days of hospitalization for each benefit period. The 90 days are renewable when you start another benefit period after a wait of 60 days. Medicare pays in full for the first 60 days of a hospital stay, except for a $592 (1990) deductible. From the 61st through the 90th day in a hospital during each benefit period, Part A coverage pays for all covered services except for $148 (1990) a day.

Medicare hospital insurance covers an additional 60 hospital days, referred to as "lifetime reserve days," if you have a long illness and have to stay in the hospital for more than 80 days. *Once you use a reserve day you never get it back.* Part A pays for all covered expenses except for $296 (1990) a day for each reserve day you use. Less than 2 percent of beneficiaries use even 1 day of these lifetime reserve days.

Part B (Medical Insurance)

Part B coverage is obtained by paying a monthly premium of $28.60 (1990) which usually is deducted from your monthly Social Security check. It is important to remember that the premium is subject to change on an annual basis.

Part B coverage helps pay for doctors' services, outpatient hospital care, physical therapy, speech pathology services, and home health care. It also helps pay for a number of other benefits, including diagnostic tests, prosthetic devices, medical supplies, independent laboratory tests, certain ambulance services, radiology and pathology services, administration of drugs that you cannot administer yourself, limited chiropractic, podiatric, outpatient psychiatric care, and dental surgery.

After you have paid a $75 deductible, Part B will pay for 80 percent of the "allowed" or Medicare-approved charges for any additional covered services during the rest of the year. You are responsible for the remaining 20 percent plus any amount of the physician's charges in excess of the approved amount.

When seeking medical services, ask your doctor if he or she will accept Medicare "assignment." If your physician accepts assignment payments as a "participating" physician (a list of "participating" physicians should be available from your closest Social Security office or area agency on aging), it means he or she agrees to accept

the fee "allowed" (i.e., covered) by the Medicare system. Your physician may also accept Medicare assignment on a case-by-case basis. Be sure to persist in finding this out. If your physician does not accept Medicare assignment, you may be charged the excess over the "allowed" charge, in addition to the 20 percent portion you must pay under the Medicare Program.

AN EXAMPLE

[Amounts in dollars]

	Actual charge	Medicare "allowed" charge	Out-of-pocket cost to beneficiary
Participating physician [1]	100	100	[2] 20
Nonparticipating physician [3]	200	100	[4] 120

[1] A participating physician will receive payment directly from Medicare.

[2] 20 percent of "allowed" charge.

[3] With a nonparticipating physician, you must front the cost and then follow-up with Medicare or your supplement insurer for reimbursement.

[4] 20 percent of "allowed" ($20) plus excess over "allowed" charge $100.

THE COVERAGE GAPS

A quick review of the Medicare Program reveals some obvious gaps in health coverage for the elderly. Clearly, a Medicare beneficiary is responsible for paying program deductibles and co-insurance. These can add up very quickly. Less obvious, but equally important, is the fact that Medicare does not cover the costs of custodial nursing home care, outpatient prescription drugs, or certain other forms of care.

The Hospital Coverage Gap

A serious illness resulting in a long hospital stay may involve sizable out-of-pocket expenses which you must pay, including:*

- $592 deductible;
- $148 a day co-payment charge for 30 days, beginning with the 61st to the 90th day of a hospital stay (a beneficiary would potentially be liable for a total of $4,440);
- $296 a day co-payment for each reserve day you might use plus total costs after reserve days run out (100 reserve days would amount to a maximum of $29,600); and
- $74 a day for days 21 through 100 of skilled nursing care only after a hospital stay of at least 3 days (days 21 through 100 would amount to a total of $5,826).

The Physician Coverage Gap

Gaps in physician coverage could result in thousands of dollars of costs not covered by Medicare.

If a physician does not accept assignment, possible uncovered costs include:*

- $75 deductible;
- 20 percent of all Medicare "approved" physician costs; and
- 100 percent of any excess charges above Medicare "approved" costs.

Other costs not usually covered by Medicare include those for:

- Routine immunizations, routine foot care, and cosmetic surgery.
- Routine examinations such as physicals, eye examinations (refractions), dental care, hearing, and podiatric care.
- Routine eyeglasses, hearing aids, and dentures.

In addition, Medicare does not cover the cost for care provided outside of the United States (although limited exceptions for Mexico and Canada exist), or costs for services that are not determined to be medically necessary.

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*Figures are for 1990 only.

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As you can see, a participant's exposure for large physician bills could be great. For example, a $10,000 doctor bill with $7,000 in "approved" charges could cost the participant up to $4,475 in out-of-pocket doctor bills ($75 deductible, $1,400 co-payment, $3,000 excess payment).

The Prescription Drug Gap

Although Medicare will cover the cost of drugs furnished during a hospital stay, it will not pay for any prescription drug costs after you leave the hospital or skilled nursing facility, and Medicare covers very few drugs provided on an outpatient basis (Medicare will cover certain forms of chemotherapy and nutrition therapy under very limited circumstances). Prescription drug costs have increased at a higher rate than other medical costs and represent, for most older Americans, their highest out-of-pocket costs.

The Nursing Home Care Gap

Medicare pays for only limited skilled nursing care in a nursing home through the SNF benefit. Most nursing home residents do not meet the stringent criteria necessary for the SNF benefit. In particular, custodial care (which includes assistance with activities of daily living such as bathing, dressing, and eating) is not covered under Medicare. Medicare does, however, cover assistance with activities of daily living when included as part of covered SNF care.

OPTIONS FOR FILLING IN MEDICARE'S GAPS

COVERING THE COSTS OUT OF YOUR OWN POCKET

Some older Americans may feel that they are able to cover all their health care expenses out of their own pockets. However, it is important to keep in mind that the cost of medical care has increased almost twice as fast as the costs of other goods and services in the last decade. Thus, personal resources that are adequate today may not suffice in the future.

CONTINUING A GROUP POLICY YOU JOINED PRIOR TO REACHING AGE 65

Many employers allow retirees to convert their group insurance to a Medicare supplement after retirement. In 1986, 68 percent of health plan participants in

medium and large size firms were entitled to health coverage after retirement.

If that is the case with your former employer, examine the benefits and costs of your plan in comparison to other supplemental policies. If you switch to another supplemental policy, be sure to continue coverage under your old policy long enough to cover any waiting periods the new policy may have. (A waiting period is the time between the date when you become insured and the date when the policy will pay benefits for a pre-existing condition or certain specified illnesses.) Otherwise, you may not be protected for as much as 6 months.

Do not drop your policy without adequate advice. If the premium is paid by the employer, or even if a small amount is paid by you (the retiree), it is sometimes prudent to retain it and buy a minimum benefit supplemental policy for complete coverage.

RECEIVING HEALTH BENEFITS FROM THE WORKPLACE IF AGE 65 OR OVER

If you are employed and age 65 or over, or married to someone who is employed and age 65 or over, you may be protected by Federal law. Federal law requires that employers with 20 or more employees offer employees over age 65 and their dependents the same health insurance coverage offered to younger workers. Also, at age 65, a worker becomes eligible for Medicare, which pays its benefits after the employer's plan pays. Consult your employer for information about Medicare "secondary payer" rules that apply to employer group coverage for people who continue to work after they reach age 65.

CHOOSING A SUPPLEMENTAL (MEDIGAP) POLICY

The purpose of a Medicare supplemental policy is to fill the gaps in Medicare coverage. Policies that are called Medicare supplements *cover services only after Medicare pays first.* These policies are sometimes referred to as Medigap policies. However, if Medicare denies payment for services, the Medicare supplement may not pay for those services. Older Americans generally need only one comprehensive Medicare supplement. Twenty-five percent of all insurance dollars spent by seniors is for unnecessary or overlapping coverage.

MEDICARE SUPPLEMENTAL POLICIES VARY IN TERMS OF COVERAGE

Medigap "thrifty models" provide the minimal coverage required by law: After exhausting all Medicare hospital inpatient benefits including the lifetime reserve days, this type of policy covers 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days; the Part A blood deductible; and the Part B 20 percent coinsurance.

Other Medigap models vary in terms of coverage paying anything from the Part A deductible to Part B expenses to coverage of prescription drugs. Make sure you do not pay for benefits you do not want or need.

CHOOSING A HEALTH MAINTENANCE ORGANIZATION

Health Maintenance Organizations (HMOs) are a relatively new option for Medicare beneficiaries. HMOs differ from health insurance and fee-for-service physician care in that they provide and finance health care. In an HMO, you pay a monthly or annual premium. In exchange for the fee, you will not be charged substantial additional costs for your medical care. A Medicare HMO may absorb the Medicare deductibles or co-insurance, and provide additional benefits. A Medicare HMO can provide you with all Medicare-approved services.

To be eligible for an HMO, you must be enrolled in Medicare's Part B. Also, you must either have Part A of Medicare or pay a higher monthly premium to the HMO. You also must live in the HMO's geographical area for at least 9 months of the year.

Medicare recipients cannot be denied enrollment to an HMO because of advanced age, or any "pre-existing medical condition," no matter how severe, with the exception of persons with end-stage renal disease or in a hospice benefit period. Medicare HMOs are required to have at least one 30-day open enrollment period every year.

HMOs provide all services that you receive under Medicare, as well as some additional services. For example, some HMOs cover inpatient hospitalization costs in full, including the Medicare deductible. Other services may include immunizations, prescription drugs at re-

duced cost, routine eye care, physical examinations, and others. The costs and benefits vary from plan to plan.

TIPS ABOUT PURCHASING SUPPLEMENTAL HEALTH INSURANCE

Here are some important factors to consider:

- Identify *Medicare's gaps* to determine what is important to you in a Medicare supplemental policy. Also consider such policy features as premiums, waiting periods, pre-existing condition exclusions, and maximum benefit clauses.
- *Take into account any other coverage you have* that continues beyond age 65.
- *Consider how much you can afford to pay* out of your own pocket for hospital or medical bills and how much you can afford to pay for supplemental health insurance premiums.
- *Find out which doctors accept Medicare assignment and are participating physicians.* Lists should be available at your nearest Social Security office or area agency on aging.
- *Work with hometown agents and companies that you know.* A company must meet certain qualifications to do business in your State. In most States, agents must also be licensed by the State and must carry proof of licensing showing their name and the company they represent. Ask whether they belong to any professional organization so you can check their credentials.
- *Talk with your friends* who have good claims experience with their Medigap policies.
- *Investigate group insurance sold by legitimate organizations and associations.* Some of the senior citizen or retired person organizations are "legitimate" and others are "gimmicks" set up as fronts to get your business. And while some of these plans are good deals, others are expensive and not as good as individual plans.
- *As a general rule, purchase one good comprehensive Medicare supplemental policy.* There are some exceptions if you have an employer group policy that is affordable, but limited in benefits. In this case, it may be advisable to have someone knowledgeable go over the options with you.

- *Check for special circumstances* for which the insurance company may eliminate coverage for a health condition you had before you bought the policy. A policy may refer to this as a "pre-exising condition."
- *Beware of replacing existing coverage.* Be suspicious of a suggestion that you give up any policy and buy a replacement. Replacement policies should meet the 1990 standards established by the National Association of Insurance Commissioners which prevent insurers replacing coverage from imposing any additional or new pre-existing condition, waiting, elimination, or probationary periods.
- *Check your right to renew.* Beware of policies that let the company refuse to renew your policy on an individual basis. Pursuant to 1990 standards established by the National Association of Insurance Commissioners, policies must be guaranteed renewable.
- *Remember, policies to supplement Medicare are neither sold nor serviced by State or Federal governments.* Do not be misled into assuming such policies are government-sponsored.
- *Don't pay cash for insurance.* Write a check or money order payable to the company, not the agent. However, you should not pay for the annual premium until you have received the policy; a deposit should suffice (e.g., 1 month's premium).
- *Keep the agent's and/or company's name(s), address(es), and telephone number(s).* In case of problems you should be able to contact them easily.
- *Take your time.* The Medigap insurance market is highly competitive with abundant products to choose from. Do not let a short-term enrollment period pressure you. Most legitimate policies will not have limited enrollment periods. Some States prohibit special enrollment periods.

KNOW YOUR RIGHTS

It is important to know your rights. *Any agent trying to sell you a Medigap policy that duplicates either your*

Medicare coverage or any private insurance you have may be subject to criminal penalties. Anyone pretending that he or she is from Medicare or any Government agency is also subject to such penalties. If you own Medicare supplemental policies with overlapping benefits or have ever had an agent tell you that he or she represented Medicare or a Government agency, notify your State Department of Insurance.

There are minimum standards that policies must meet to be labeled Medicare supplements. They apply only to policies issued after 1980 and they do *not* apply to other policies such as long-term care insurance, hospital indemnity policies, or dread disease policies. The minimum standards for Medicare supplement policies are:

—Pre-existing conditions may not be excluded after the policy has been in force for 6 months.

—Individual policies must pay out 60 or 65 percent (depending on the State) of all premiums collected as benefits to the purchasers of the policy. Group policies must pay out 75 percent on group coverage. (Employer furnished contracts are exempt from this.)

—Older consumers are entitled to a 30-day free-look period (from the date of delivery of the policy) during which time the policy may be returned and the premium refunded.

In addition, the policy you buy should meet the 1990 standards established by the National Association of Insurance Commissioners, which include:

—Coverage of either all or none of the Part A deductible;

—Coverage of Part A hospital co-insurance amounts;

—90 percent of hospital costs after Medicare hospital benefit is used up—not to exceed 365 days;

—Part A blood deductible; and

—Part B—20 percent co-insurance.

TIPS ABOUT HEALTH MAINTENANCE ORGANIZATIONS (HMO's)

Here are some important factors to consider:

- *The HMO handles the paperwork.* You don't have to file any claims.

- *You must obtain all health care services through the HMO.* Selection of physicians and hospitals is limited to those contracting with or employed by the HMO. You will not be covered for services outside the HMO except under very limited circumstances. You choose your doctor from a list provided by the HMO. You can't see a specialist without approval from your "primary care physician" (internist or family doctor). However, emergency situations would be covered. Check to see if your doctor or hospital participates with the HMO. Your present doctor may also see HMO patients.
- *If you travel frequently, the HMO might not meet your health care needs.* Check individual programs carefully—some large HMOs offer "reciprocity" which allows you access to services in other cities and States. Most HMOs, however, will not cover you for travel with the exception of emergency situations.
- *When you are a member of an HMO, you have fewer out-of-pocket expenses.* In effect, HMO physicians "accept assignment" from Medicare as payment in full. In most HMO's, an office call is either free or has a small cost. Hospitalization is paid for completely.
- *In some cases your care may be given by nurse practitioners or others* under the supervision of the doctor.
- *If you are unhappy with your HMO doctor, you may choose another HMO doctor.* If you are dissatisfied with the HMO, you may leave it. However, you might not be able to join another HMO right away, because the "open enrollment" period could be over. You could wait up to 11 months to join another, but you would still get your standard Medicare coverage back if you left the HMO.
- *Monthly premium rates are guaranteed for 1 year only.*
- *Medicare HMO plans are meant to be inclusive health care plans to replace the need for supplemental insurance or Medigap policies.* Further, if you leave the HMO and then reapply for supplemental insurance, it could be difficult or expen-

sive to obtain a comprehensive policy if you have a serious "pre-existing medical condition."

- *Like other Medigap supplements, the HMO doesn't cover every possible health problem.* For example, most plans do not cover long-term care except for the few short-term acute nursing home care stays currently allowed under the Medicare Program. To date, dental care, eyeglasses, and hearing aids are not routinely covered. Therefore, it is important to compare benefit levels among plans.
- *If the HMO goes out of business, or if the HMO drops its Medicare plan, it must give you 60 days advance written notice.* In either case, you would still have your basic Medicare coverage. In addition, the HMO must provide you with coverage for any pre-existing condition for at least 6 months.

SHORT TERM INSURANCE FOR TRAVEL ABROAD

If you only travel abroad once in awhile, you may want to purchase a *short-term travel policy.* These policies are available through travel agents and can be adjusted to your needs. Unless you travel often, do not buy a Medicare supplement based on this option.

LIMITED POLICIES TO STAY AWAY FROM

There are several types of limited policies that may be advertised by celebrities and sound like wise choices. However, they are often not designed to fill in Medicare's gaps and are, frequently, a waste of premium dollars. These policies often duplicate coverage already included under Medicare and a comprehensive supplement policy. Thus it is probably more prudent to concentrate your premium dollars in the most comprehensive supplement policy that you can get. Limited policies include the following:

Hospital Indemnity Policies.—Indemnity policies, which are of limited value for most, pay a fixed amount each day, week, or month while you are in the hospital. They will pay you regardless of whether you have other hospital coverage. However, you cannot collect unless you are in the hospital. Hospi-

tal indemnity policies are probably not wise choices for filling in Medicare's gaps.

Accident Only Policies.—Accident only policies provide coverage for death, dismemberment, or hospital and medical care due to an accident. They are not designed to pay routine health care costs. These policies are of limited value for most.

Dread Disease Policies.—Dread disease policies cover you for specific diseases like cancer. These policies pay in few situations and a number of States have banned their sale.

MEDICAID AND VETERANS' BENEFITS

Medicaid pays for medical and nursing home care for certain categories of people who have limited income and assets. If you are a Medicare recipient and cannot afford supplemental insurance, are not eligible for Medicare, or you are over 65 and have a low income, you should investigate the possibility of receiving Medicaid assistance. In many States, if you are eligible for Supplemental Security Income (SSI), you are also eligible for Medicaid. In order to find out if you are eligible for Medicaid, contact your closest State or county Department of Social Services. (You may be able to obtain information from your local area agency on aging.) If you already receive Medicaid assistance, supplemental insurance is not necessary.

Veterans' Benefits.—If you are eligible for veterans' benefits, you may receive more comprehensive coverage than you would under Medicare. For example, in addition to hospitalization, veterans with service-related disability *may* qualify for treatment in a VA or private nursing home. Eligible veterans may have to wait for an available bed to receive treatment, however. To apply for veterans' benefits, contact your closest Department of Veterans Affairs office.

NURSING HOME AND HOME CARE LONG-TERM CARE POLICIES

Gains in life expectancy in this century have resulted in a greater number of persons living to advanced ages, and as a consequence, these people are more likely to suffer from various chronic conditions, or to experience declines in their ability to function independently.

Long-term care is the wide range of medical and support services that may be available for people who, as a result of these conditions, need help in caring for themselves over long periods of time, often for as long as the person receiving the service lives. Individuals in need of such care may require part- or full-time help. The help may range from high-technology services for those dependent upon ventilators to low-technology services such as cooking or shopping. Although many assume that most long-term care takes place in nursing homes, the truth is that the majority of long-term care services are provided in the home by family members.

PROTECTING AGAINST THE COST OF LONG-TERM CARE

More than half of nursing home costs are paid for by nursing home residents or their families.—Medicare pays for less than 2 percent of nursing home costs and Medicare supplement or long-term care insurance pays even less. Medicaid pays for nursing home care, and sometimes home-health care, for those who meet low-income requirements. Medicaid covers about 44 percent of all nursing home expenditures.

Facts to remember about long-term care:

—*Medicare does not pay for long-term care.* It does pay for skilled nursing facility and home health care benefits, but these must be medically related and are short-term in nature;

—Medicare supplemental plans do not pay for long-term care; and

—In order for Medicaid to pay for long-term care you must meet low-income requirements.

At present there are not many options for protecting against the costs of long-term care. Financing such care is an issue which is being examined by many, including Congress. A relatively new form of protection against long-term care costs that is receiving a great deal of attention is long-term care private insurance.

Long-Term Care Insurance is Not for Everyone.—Long-term care insurance has begun to be marketed by the insurance industry within the last few years. Typically, long-term care policies offer benefits for a limited range of services provided in a nursing home and, to a far lesser extent, at home. They have been very restrictive in providing benefits and typically are expensive. A

recent study by the United Seniors Health Cooperative in Washington, D.C., reported that holders of nursing home policies in 1988 had a 2 in 5 chance of collecting coverage. However, as interest in these products has increased, policies are improving.

Careful consideration should be given to the purchase of long-term care insurance. Long-term insurance is not for everyone. Some advocates recommend that, in general, if a person's income is under $20,000 and assets and savings are under $30,000 (excluding a home), it may not be a good option.

Checking Out Policy Variables.—Very few long-term care policies cover everything. In addition, few policies provide care for indefinite periods of time. For most people, nursing home care is thought of as a last resort and they prefer, whenever possible, that long-term care should be provided at home.

TIPS ABOUT PURCHASING LONG-TERM CARE INSURANCE

The following are the options you will need to consider when purchasing a long-term care policy. It is also worthwhile to review the warnings on supplemental insurance in this publication; they apply to long-term care insurance as well.

● *Determine the level of care that the policy covers.* Level of care refers to the intensity of care and types of services needed by individuals. Distinctions in level of care also describe facilities and the care they can and do provide. Policy definitions for levels of care are usually not the same. Avoid policies which require that you first be admitted to a nursing home at a skilled level of care before the insurance company will pay for another level of care. Also, beware of policies which reduce the amount of benefit for lesser levels of care. Here are the three major recognized levels of care:

Skilled Care is intended to return a patient to a former level of care. It includes *daily skilled nursing or rehabilitative inpatient services* which are administered by skilled personnel, such as a registered nurse, physical therapist, speech pathologist, or medical doctor. Care must be based on a doctor's orders.

Intermediate Care includes *occasional care* provided by skilled nursing or rehabilitative professionals. It also includes nonskilled care provided by paraprofessionals such as nurse aides. Care is based on a doctor's orders and is provided under the supervision of skilled medical personnel.

Custodial Care provides *personal assistance* in activities of daily living such as bathing, dressing, and giving oral medications. Such services can be performed by the average nonmedical person. Care can be based on a doctor's certification that such care is necessary.

- *Make sure that any policy that you consider provides inflation protection for the daily coverage rate.* (Inflation protection will ensure that the daily coverage rate automatically increases with each year for a certain number of years in order to keep up with inflation.) Daily policy rates are usually $20 to $100 a day. (At present, the average national cost of a nursing home is between $65 to $70 a day.)
- *Find out how long the policy will provide benefits.* Policies do vary. Keep in mind that for those who are admitted to a nursing home for a chronic condition and stay for more than 3 months, the average length of stay is 2.5 years.
- *Do not buy policies with a requirement for prior hospitalization.* Many policies have prior hospitalization requirements which means that you must be hospitalized first before the insurance company will cover nursing home costs. However, many people who enter nursing homes need custodial care without first needing hospitalization and it is not easy for a physician to "admit you in the hospital for a few days."
- *Make sure the policy covers the levels of care which you want to have covered.*
- *Avoid purchasing a long-term care policy with a period of confinement of more than 90 days.* Long-term care policies include requirements called *periods of confinement* or *period of care provisions* that tell you how long you must stay out of the hospital or nursing home before you will have to go through a new waiting or deductible period.
- *If you choose to purchase a policy with a waiting period, make sure you understand how much you will have to pay out-of-pocket before any coverage begins.*

Policies usually state that for a certain period of time from the effective date, such as 6 months or maybe 2 years, the policy will not cover you for any medical condition that you already had. This is called a waiting period for preexisting conditions. During a nursing home stay, you will have to pay all of the costs. Because of the costs, a waiting period longer than 6 months does not make sense for many people. Keep in mind that these policies are designed to be purchased in advance of need.

- *Closely review the cost implications of an elimination period.* This means that before the policy will pay benefits, you will have to cover all of the costs for a certain amount of days. The longer the elimination period, the less expensive the premium. Most policies will give you a choice of 0 to 120 days.
- *Make sure you are aware of what exclusions your policy contains.* Many people enter nursing homes because of disorders such as Parkinson's or Alzheimer's diseases. Some policies will not pay for care for these related disorders. There are many ways for a company to exclude such disorders by using confusing language.
- *Remember that most good policies do not require the policyholder to continue to pay premiums while you are in a nursing home.* (Typically, after 90 days of benefits the premiums are waived. This is often referred to as waiver of premium provisions.)
- Most policies are not sold to persons over a certain age, usually 80 or 85. (Premiums go up with increasing age.) *Try to avoid buying a policy that states premiums will go up with attained age.* Even if you purchase a policy prior to age 65, you should carefully examine what you buy.
- *Do not buy an individual long-term care insurance policy that is not "guaranteed renewable for life."* Policies that are individual, in other words not sold on a group basis, should be guaranteed renewable. This means that the insured person has the right to continue the policy as long as he or she continues to pay premiums.
- *Be truthful when responding to questions from insurers about long-term care insurance.* You will be asked a number of questions and/or you will need to submit a physician's report. These are used by insurance companies for health underwriting to determine how insur-

able you are and withholding information can jeopardize future claims or cause a policy to be cancelled.

● *Remember that the National Association of Insurance Commissioners (NAIC) has recently adopted long-term care insurance standards which States are now expected to adopt.*

FOR MORE INFORMATION

If you need additional help or assistance in purchasing Medicare supplemental or long-term care insurance, contact your State Insurance Department or State Agency on Aging. (See lists in the back of this report.) However, there are other avenues of assistance for you to pursue when purchasing a Medigap or long-term care insurance policy, only some of which are listed below.

—If one exists in your State, a health insurance counseling program. A list of States with counseling programs can be found in the back of this report.

—If your State does not have a counseling program (and even if it does), your local community may have some form of a counseling program. These counseling programs may be run by consumer advocate organizations, such as the American Association of Retired Persons, or even by insurance companies or agents. (Because of conflict of interest concerns, many advocates recommend avoiding counseling programs run by insurance companies.) Your local area agency on aging can tell you if a counseling program is near you.

—Senior centers frequently offer a variety of informational publications to local senior citizens. Ask your center if they have materials on Medigap and/or long-term care insurance.

—Local libraries also may have valuable background information on insurance and likely will have other informational publications.

—If you believe that you have been victimized by unfair, abusive, or fraudulent insurance practices, you may want the advice or assistance of an attorney. Your State or Area Agency on Aging can direct you to attorneys who provide low or no-cost legal services to older Americans.

Finally, included in the back of this report are forms which the California Department of Insurance prepared

that can help guide you in choosing the supplemental insurance policy that best meets your needs.

STATE INSURANCE DEPARTMENTS

[Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance.]

Alabama
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130-3401
(205) 269-3550

Alaska
Alaska Insurance Department
3601 C Street, Suite 740
Anchorage, AK 99503
(907) 562-3626

American Samoa
American Samoa Insurance Department
Office of the Governor
Pago Pago, AS 96797
011-684/633-4116

Arizona
Arizona Insurance Department
Consumer Affairs and Investigative Division
3030 N. Third Street
Phoenix, AZ 85012
(602) 255-4783

Arkansas
Arkansas Insurance Department
Consumer Service Division
400 University Tower Building
12th & University Streets
Little Rock, AR 72204
(501) 371-1813

California
California Insurance Department

Consumer Services Division
3450 Wilshire Boulevard
Los Angeles, CA 90010
1-800-233-9045

Colorado
Colorado Insurance Department
303 W. Colfax Ave., 5th Floor
Denver, CO 80204
(303) 620-4300

Connecticut
Connecticut Insurance Department
165 Capitol Avenue
State Office Building
Hartford, CT 06106
(203) 297-3800

Delaware
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
(302) 736-4251

District of Columbia
District of Columbia Insurance Administration
613 G Street NW., Room 619
P.O. Box 37200
Washington, DC 20001-7200
(202) 727-8017

Florida
Florida Department of Insurance
State Capitol, Plaza Level Eleven
Tallahassee, FL 32399-0300
Toll-Free (Within State)
1-800-342-2762
(904) 488-0030

Georgia
Georgia Insurance Department
2 Martin L. King, Jr. Drive
Room 716 West Tower
Atlanta, GA 30334
(404) 656-2056

Guam
Guam Insurance Department
855 W. Marine Drive

P.O. Box 2796
Agana, GU 96910
011-671/477-1040

Hawaii
Hawaii Department of Commerce
and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, HI 96811
(808) 548-5450

Idaho
Idaho Insurance Department
Public Service Department
500 S. 10th Street
Boise, ID 83720
(208) 334-3102

Illinois
Illinois Insurance Department
320 W. Washington Street, 4th Floor
Springfield, IL 62767
(217) 782-4515

Indiana
Indiana Insurance Department
311 W. Washington Street
Suite 300
Indianapolis, IN 46204
(317) 232-2395

Iowa
Iowa Insurance Division
Lucas State Office Building
E. 12th & Grand Sts., 6th Floor
Des Moines, IA 50319
(515) 281-5705

Kansas
Kansas Insurance Department
420 S.W. 9th Street
Topeka, KS 66612
(913) 296-3071

Kentucky
Kentucky Insurance Department
229 West Main Street
P.O. Box 517

Frankfort, KY 40602
(502) 564-3630

Louisiana
Louisiana Insurance Department
P.O. Box 94214
Baton Rouge, LA 70804-9214
(504) 342-5900

Maine
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta, ME 04333
(207) 582-8707

Maryland
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore, MD 21202-2272
(301) 333-2792

Massachusetts
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston MA 02114
(617) 727-7189

Michigan
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
(517) 373-0220

Minnesota
Minnesota Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101
(612) 296-4026

Mississippi
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

Missouri
Missouri Division of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO 65102-0690
(314) 751-2640

Montana
Montana Insurance Department
126 N. Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena, MT 59604
Toll-Free (Within State)
1-800-332-6148
(406) 444-2040

Nebraska
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
(402) 471-2201

Nevada
Nevada Department of Commerce
Insurance Division
Consumer Section
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270

New Hampshire
New Hampshire Insurance Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
(603) 271-2261

New Jersey
New Jersey Insurance Department
20 W. State Street
Roebling Building
Trenton, NJ 08625
(609) 292-4757

New Mexico
New Mexico Insurance Department

P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

New York
New York Insurance Department
160 W. Broadway
New York, NY 10013
New York City
(212) 602-0203
Toll-Free (Within State Outside of NYC)
1-800-342-3736

North Carolina
North Carolina Insurance Department
Consumer Services
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
(919) 733-2004

North Dakota
North Dakota Insurance Department
Capitol Building
5th Floor
Bismarck, ND 58505
(701) 224-2440

Ohio
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
(614) 644-2673

Oklahoma
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
(405) 521-2828

Oregon
Oregon Department of Insurance and Finance
Insurance Division/Consumer Advocate
21 Labor and Industry Building
Salem, OR 97310
(503) 378-4484

Pennsylvania
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

Puerto Rico
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

Rhode Island
Rhode Island Insurance Division
233 Richmond Street, Suite 233
Providence, RI 02903-4233
(401) 277-2223

South Carolina
South Carolina Insurance Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202-3105
(803) 737-6140

South Dakota
South Dakota Insurance Department
Enforcement
910 E. Sioux Avenue
Pierre, SD 57501-3940
(605) 773-3563

Tennessee
Tennessee Department of Commerce and Insurance
Policyholders Service Section
500 James Robertson Parkway
4th Floor
Nashville, TN 37243-0582
Toll-Free (Within State)
1-800-342-4029
(615) 741-4955

Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Boulevard
Austin, TX 78701-1998
(512) 463-6501

Utah
Utah Insurance Department
Consumer Services
3110 State Office Building
Salt Lake City, UT 84114
(801) 530-6400

Vermont
Vermont Department of Banking and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
(802) 828-3301

Virgin Islands
Virgin Islands Insurance Department
Kongens Garde No. 18
St. Thomas, VI 00802
(809) 774-2991

Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

Washington
Washington Insurance Department
Insurance Building AQ21
Olympia, WA 98504-0321
Toll-Free (Within State)
1-800-562-6900
(206) 753-7300

West Virginia
West Virginia Insurance Department
2019 Washington Street, E.
Charleston, WV 25305
(304) 348-3386

Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
(608) 266-0103

Wyoming
Wyoming Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
(307) 777-7401

STATE AGENCIES ON AGING

[The offices listed in this section are responsible for administering and coordinating services for older Americans on a statewide basis]

Alabama
Commission on Aging
136 Catoma Street
Montgomery, AL 36130
Toll-Free (Within State)
1-800-243-5463
(205) 242-5743

Alaska
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465-3250

American Samoa
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633-1251

Arizona
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 542-4446

Arkansas
Division of Aging and Adult Services
Donaghey Plaza South, Suite 1417
7th and Main Streets
P.O. Box 1417/Slot 1412
Little Rock, AR 72203-1437
(501) 682-2441

California
Department of Aging

1600 K Street
Sacramento, CA 95814
(916) 322-3887

Colorado
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203-1714
(303) 866-3851

Commonwealth of the Northern Mariana Islands
Department of Community and Cultural Affairs
Civic Center
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
(670) 234-6011

Connecticut
Department of Aging
175 Main Street
Hartford, CT 06106
Toll-Free (Within State)
1-800-443-9946
(203) 566-7772

Delaware
Division of Aging
Department of Health and Social Services
1901 N. DuPont Highway
New Castle, DE 19720
(302) 421-6791

District of Columbia
Office on Aging
Executive Office of the Mayor
1424 K Street N.W., 2nd Floor
Washington, D.C. 20005
(202) 724-5626
(202) 724-5622

Federated States of Micronesia
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.1. 96941

Florida
Office of Aging and Adult Services

1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-8922

Georgia
Office of Aging
Department of Human Resources
878 Peachtree Street, NE
Room 632
Atlanta, GA 30309
(404) 894-5333

Guam
Division of Senior Citizens
Department of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-2942

Hawaii
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 548-2593

Idaho
Office on Aging
Statehouse, Room 114
Boise, ID 83720
(208) 334-3833

Illinois
Department on Aging
421 E. Capitol Avenue
Springfield, IL 62701
(217) 785-2870

Indiana
Department of Human Services
251 North Illinois
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7020

Iowa
Department of Elder Affairs
Suite 236, Jewett Building
914 Grand Avenue

Des Moines, IA 50319
(515) 281-5187

Kansas
Department on Aging
122-S. Docking State Office Building
915 SW Harrison
Topeka, KS 66612-1500
(913) 296-4986

Kentucky
Division for Aging Services
Department for Social Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6930

Louisiana
Governor's Office of Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898-0374
(504) 925-1700

Maine
Maine Committee of Aging
State House, Station 127
Augusta, ME 04333
(207) 289-3658

Maryland
State Agency on Aging
301 W. Preston Street
Baltimore, MD 21201
(301) 225-1102

Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll-Free (Within State)
1-800-882-2003
(617) 727-7750

Michigan
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373-8230

Minnesota
Minnesota Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul, MN 55155-3843
(612) 296-2770

Mississippi
Council on Aging
301 W. Pearl Street
Jackson, MS 39203-3092
Toll-Free (Within State)
1-800-222-7622
(601) 949-2070

Missouri
Division of Insurance
Truman Building 630
P.O. Box 690
Jefferson, MO 65102-0690
Toll-Free (Within State)
1-800-235-5503

Montana
Department of Family Services
P.O. Box 8005
Helena, MT 59604
(406) 444-5900

Nebraska
Department on Aging
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-2306

Nevada
Department of Human Resources
Division for Aging Services
505 E. King Street
Room 101
Carson City, NV 89710
(702) 885-4210

New Hampshire
Department of Health and Human Services
Division of Elderly and Adult Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4394

New Jersey
Department of Community Affairs
Division on Aging
S. Broad and Front Streets
CN 807
Trenton, NJ 08625-0807
(609) 292-0920

New Mexico
Agency on Aging
La Villa Rivera Building
4th Floor
224 E. Palace Avenue
Santa Fe, NM 87501
Toll-Free (Within State)
1-800-432-2080
(505) 827-7640

New York
State Office for the Aging
Agency Building
2 Empire State Plaza
Albany, NY 12223-0001
Toll-Free (Within State)
1-800-342-9871
(518) 474-5731

North Carolina
Department of Human Resources
Division of Aging
1985 Umstead Drive
Raleigh, NC 27603
(919) 733-3983

North Dakota
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2577

Ohio
Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

Oklahoma
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-2327

Oregon
Department of Human Services
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll-Free (Within State)
1-800-232-3020
(503) 378-4636

Palau
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

Puerto Rico
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429 or 722-0225

Republic of the Marshall Islands
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

Rhode Island
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
(401) 277-2858

South Carolina
Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223
(803) 735-0210

South Dakota
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3656

Tennessee
Commission on Aging
706 Church Street
Suite 201
Nashville, TN 37219-5573
(615) 741-2056

Texas
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78711
(512) 444-2727

Utah
Division of Aging & Adult Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-3910

Vermont
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241-2400

Virgin Islands
Department of Human Services
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-0930

Virginia
Department for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
Toll-Free (Within State)
1-800-552-4464
(804) 225-2271

Washington
Aging & Adult Services Administration
Department of Social & Health Services
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

West Virginia
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll-Free (Within State)
1-800-642-3671
(304) 348-3317

Wisconsin
Bureau on Aging
Department of Health & Social Services
P.O. Box 7851
Madison, WI 53707
Toll-Free (Within State)
1-800-242-1060
(608) 266-2536

Wyoming
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll-Free (Within State)
1-800-442-2766
(307) 777-7986

STATE HEALTH INSURANCE COUNSELING PROGRAMS

California
Mr. Wayne R. Lindley
California Department of Aging
Program Manager
Health Insurance Counseling and Advocacy Program (HICAP)
K Street
Sacramento, CA 95814
(916) 323-7315

Illinois
Ms. Bernadette Nolan
Program Director
Senior Health Insurance Program (SHIP)
Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767
(217) 782-0004

Maryland
Ms. Michelle Holzer
Coordinator of Senior Health Insurance Counseling Program (SHICP)
Maryland Office on Aging
301 West Preston Street
Baltimore, MD 21201
(301) 225-1270

New Mexico
Ms. Denese Mueller
Program Manager
Health Insurance Benefits Assistance Program (HIBAC)
New Mexico Agency on Aging
224 East Palace Ave.
Fourth Floor
Santa Fe, NM 87501
(505) 827-7640

Idaho
Mr. Ken Hurt
Program Specialist
Senior Health Insurance Benefits Advisors (SHIBA)
Idaho Department of 1600 Insurance
500 S. 10th Street
Boise, ID 83720
(208) 334-2250

Iowa
Ms. Kris Gross
Senior Health Insurance Advocate
Protection & Advocacy Through Community Training, Iowa Insurance Division (PACT)
Lucas State Office Building
Sixth Floor
Des Moines, IA 50319
(515) 242-5190

Massachusetts
Ms. Maureen Barton
Program Director
Serving Health Information Needs of Elders (SHINE)
Executive Office of Elder Affairs
38 Chauncey Street
Boston, MA 02111

New Jersey
Ms. Theresa Dietrich
Coordinator: Senior Health Insurance Program (SHIP)
Department of Community Affairs
Division of Aging
CN 807
Trenton, NJ 08625
(609) 292-4303

North Carolina
Ms. Alice Garland
Assistant Commissioner
Department of Insurance
Senior Health Insurance Information Program (SHIIP)
P.O. Box 26387
Raleigh, NC 27611
(919) 733-0433

Ohio (Pilot Program)
Mr. Joseph Mancini
Office of Attorney General
Health, Education and Human Services Section
State Office Tower
30 East Broad Street
Columbus, OH 43215
(614) 466-8600

Washington
Ms. June Mulkahey
Deputy Commissioner
Senior Health Insurance Benefits Advisors (SHIBA)
Insurance Building
Olympia, WA 98504
(206) 753-2408

Wisconsin
Ms. Jane Raymond
Benefit Specialist Program Liaison
Wisconsin Bureau on Aging
1 West Wilson Street
P.O. Box 7851
Madison, WI 53707
(608) 266-2568

FORM A

YOUR HEALTH INSURANCE POLICY INVENTORY

Use this form to list each of your current health policies. The information will help you evaluate your present insurance coverage and whether you need additional coverage. Keep the form and your policies in a safe place for reference.

BE SURE TO KEEP A COPY OF THIS FORM. DO NOT GIVE YOUR ONLY COPY TO AN AGENT.

	Insurance Company	Policy #	Type of Policy	Effective Date	Expiration Date	Premium
1.						
2.						
3.						
4.						
5.						

FORM B

AGENT IDENTIFICATION SHEET

Use this form to obtain information on any insurance agent who contacts you regarding the purchase of Medigap health insurance. Keep it with your insurance policies and other forms in a safe place. It will ensure that you know who you are dealing with and how you can contact that agent if necessary. The information can also be used to check out the agent with your local Better Business Bureau and the State Department of Insurance.

Agent's Name: _____

Agent's License Number: _____

Agent's Business Address: _____

_____

_____

_____

Agent's Telephone Number: _____

Name(s) of Insurance Company or Companies Represented by Agent: _____

_____

_____

_____

Date 1st Contacted by Agent: _____

Date(s) of Subsequent Calls by Agent: _____

_____

_____

FORM C

AGENT CERTIFICATION OF INSURANCE SALE

Ask any agent wanting to sell you Medigap Insurance to review form A, which lists your current health insurance coverage. If, after reviewing your inventory of existing policies, the agent feels you need additional coverage, ask him or her to complete this form. It will explain why the agent feels your present coverage is inadequate and why more insurance will benefit you. The agent is not required to sign this form, but you may choose not to do business with any agent who refuses.

I, the undersigned agent, hereby certify that I have reviewed and evaluated

_____ 's health insurance policy inventory
(enter applicant's name)

consisting of the following policies:

	Insurance Company	Policy #
1.		
2.		
3.		
4.		

Based on my evaluation, I have recommended that

_____ purchase additional insurance as follows:
(enter applicant's name)

	Insurance Company	Type of Policy	Policy Form #
1.			
2.			

This additional insurance is necessary for the following reasons:

_____
(Agent's Signature)

FORM D

POLICY COMPARISON SHEET AND AGENT CERTIFICATION FORM

This form should be used when you are considering replacing an existing policy with a new one. It will allow you to compare your current insurance coverage against the proposed new one.

Ask the agent to list and compare the benefits and features of the new versus the old policy. The form asks the agent to list the reasons why it is in your best interest to replace your existing policy.

A. Benefits	Existing Policy No. _____	Proposed Policy Form No. _____
1.		
2.		
3.		
4		
5.		
6.		
B. Premium		
C. Is a pre-existing condition coverage?	Yes or No. If "yes" the waiting period is _____	Yes or No. If "yes" the waiting period is _____
D. Is the policy guaranteed renewable?	☐ Yes or ☐ No	☐ Yes or ☐ No

AGENT CERTIFICATION

I, the undersigned agent, have analyzed and compared _____
(enter applicant's name)
existing policy or policies to the proposed policy and conclude that it is in the insured's best interest to replace the existing policy or policies with the proposed policy based on the following reasons:

_____

_____

_____ _____

Further, I have considered that the insured may be eligible to upgrade his/her coverage with the existing insurer, but I have advised against that for the following reasons:

_____

_____

_____

_____
(Agent's Signature)

FORM E

INSURANCE BUYER'S CHECKLIST

Before you sign any documents or pay any amount to the agent, be sure that you have:

☐ Completed your Health Insurance Policy Inventory (Form A).

☐ Carefully reviewed the application for insurance to ensure that each question is answered correctly.

☐ Received and understand each of the following items:

☐ Outline of Coverage for the Proposed Policy. (Not included in this kit, but the agent is required by law to provide you with this.)

☐ "Guide to Health Insurance for People with Medicare" published by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Dept. of Health and Human Services. (Not included in this kit, but the agent is required by law to provide you with this.)

☐ Agent Identification Sheet (Form B).

☐ Agent Certification of Insurance Sale (Form C).

☐ Policy Comparison Sheet and Agent Certification Form (if you are replacing your current policy with another—Form D).

☐ Replacement Notice—if you are replacing your current policy with another. (Not included in this kit, but the agent is required by law to provide you with it.)

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